

The Department of Vermont Health Access Medical Policy

EVALUATION TOOLS, DEFINITIONS AND CODING INFORMATION RELATED TO WHEELCHAIRS, FOR VERMONT MEDICAID PROVIDERS

ALL WHEELCHAIRS REQUIRE PRIOR AUTHORIZATION.

Last review: December 30, 2015

Revision 3:

Revision 2:

Revision 1: June 17, 2013

Original Effective: April 24, 2012

When making its determinations, the Department of Vermont Health Access (DVHA) utilizes nationally recognized, evidence-based treatment criteria, internal guidelines which reflect Medicaid Rule, and the Medicaid Rules themselves. The Vermont Medicaid Rules pertaining to prior authorization, medical necessity, and durable medical equipment including wheelchairs are available on the AHS website at <http://humanservices.vermont.gov/on-line-rules/dvha>.

Vermont Medicaid uses Healthcare Common Procedure Coding System (HCPCS) coding definitions, which are compliant with the National Correct Coding Initiative and can often help to clarify if a device fits Medicaid Rules for coverage. When the HCPCS definition does not offer sufficient clarification, additional clarification sources may be required. For example, HCPCS codes do not define “lightweight wheelchair”. For such situations, Medicare has definitions for many devices and accessories in their Local Coverage Determination (LCD) and related Articles documentation. These definitions are also utilized by Medicare’s subcontractor, PDAC, to classify specific types of wheelchairs and accessories. These definitions can be useful in clinical decision making.

All covered wheelchairs must:

- meet the beneficiary’s medical needs (Medicaid Rule [7103](#));
- match the capability of the device/accessories to the beneficiary’s medical needs within the limitations of Medicaid coverage; and
- be the least expensive, medically appropriate device (Medicaid Rule [7102.2](#)).

The documentation provided in the Wheelchair Positioning Evaluation and Prescription Form is advisory in nature. The purpose of the form is to assist equipment prescribers and durable medical equipment providers in successfully completing a Vermont Medicaid request for a mobility device. Use of the DVHA forms will facilitate the prior authorization process and result in more timely equipment acquisition.

Wheelchair Positioning Evaluation and Prescription Form

Complete this form **entirely**. Leave no spaces blank.

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Date: _____ Beneficiary Name: _____ DOB: _____

Address: _____ Phone: _____

_____ Contact Person: _____

Insurance(s): _____ Policy #: _____

Medical Conditions (include onset dates): _____

FUNCTIONAL LEVELS

Bed Mobility: _____

Transfers (technique, assist level): _____

Ambulation (distances, devices, assist): _____

Propulsion technique (specify equipment, limbs used): _____

(Over 21 only):

- Check the **mobility related activities of daily living (MRADLs)** that cannot be accomplished without the requested device. ☐ Feeding ☐ Dressing ☐ Grooming ☐ Bathing
- Check the nature of the **mobility limitation** that significantly impairs the ability to participate in MRADL activity:
 - ☐ Prevents the accomplishment of the MRADL(s).
 - ☐ Places the patient at reasonably heightened risk of morbidity or mortality in the attempt to perform MRADL(s).
 - ☐ Prevents completion of the MRADL(s) in a reasonable time frame.
- ☐ Check if the beneficiary is unable to access authorized medical transportation to medical services without the requested device.
- ☐ Check if the beneficiary **cannot** functionally ambulate within the home environment and/or a radius of 100 feet.

Comments: _____

MEDICAL STATUS

Medications: _____
Cardiovascular/Pulmonary: _____
Sensory (vision, hearing, tactile): _____
Musculoskeletal: _____
Neurological (inc. seizure): _____
Cognitive: _____
Communication: _____
Integumentary: _____

PSYCHOSOCIAL

School/employment: _____
Transportation system to medically necessary appointments: _____

If a personally owned vehicle and assistance is required for securing the wheelchair, are there consistent care providers available? ☐ Yes ☐ No ☐ N/A

Transported in w/c to medically necessary appointments? ☐ Yes ☐ No

If the chair will be used as a seat during transport:

- Is there access to the structural frame of the wheelchair? ☐ Yes ☐ No ☐ N/A
- Are there components that interfere with the utilization of the wheelchair frame for securing the chair in the vehicle? ☐ Yes ☐ No ☐ N/A Explain: _____

Prescribed chair fits into transportation to medically necessary appointments? ☐ Yes ☐ No

Ramp slope into van: ☐ 1:12 (4.5 degree) ☐ 1:10 (6 degree) ☐ 1:8 (7.5 degree) ☐ 1:6 (9 degree) ☐ N/A
☐ Other _____

Head clearance into vehicle (with tilt if applicable): ☐ Yes ☐ No

Method of chair transport (ex: car topper, fold in rear seat, transit brackets): _____

Home Visit Information:

Note that home visits performed by the prescribing therapist are strongly recommended, to ensure that the requested device is appropriate for the MRADL(s) environment.

Home entry/exit (ramp slope, stairs): _____

Terrain to medically necessary transportation (distance, condition including obstacle heights, seasonal conditions): _____

Terrain within 100 feet of home (condition including obstacle heights, seasonal conditions): _____

Threshold height and floor conditions: _____

Ramp slope into home: ☐ 1:12 (4.5 degree) ☐ 1:10 (6 degree) ☐ 1:8 (7.5 degree) ☐ 1:6 (9 degree) ☐ N/A
☐ Other _____

Turning radius needed in home: _____

Turning radius of wheelchair: _____

Door width: exit: _____ bedroom: _____ bathroom: _____

Width of prescribed chair: _____

Is the chair suitable for use in the home environment? (**Over 21 only**) ☐ Yes ☐ No

If not, explain extenuating circumstances: _____

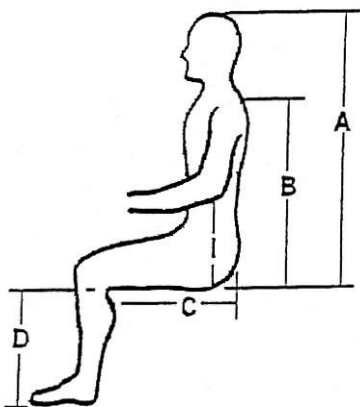
Terrain at and surrounding school/employment and community (**Under 21 only**): _____

Community transportation (**Under 21 only - ex: school bus**): _____

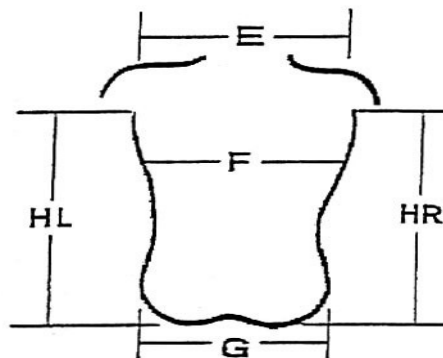
MEASUREMENTS

Height: _____

Weight: _____



A _____	F _____
B _____	G _____
C _____	HR _____
D _____	HL _____
E _____	I _____



MUSCULOSKELETAL EVALUATION

ROM/strength:	L	R
hip flexion	_____	_____
hip abd.	_____	_____
hip add.	_____	_____
hip internal r.	_____	_____
hip external r.	_____	_____

Mobility related issues:

Postural influences (tone, reflexes): _____

Previous coverage source: _____

Therapist completing the evaluation:

Professional signature: _____

Date: _____ Phone: _____

Facility: _____

Email: _____

WHEELCHAIR PRESCRIPTION:

Wheelchair Components:

Base: (Check one)

Manual wheelchairs:

- ☐ Standard
- ☐ Standard hemi height
- ☐ Lightweight
- ☐ High strength, lightweight
- ☐ Ultra-lightweight
- ☐ Heavy duty
- ☐ Extra heavy duty
- ☐ Tilt in space
- ☐ Recliner, full
- ☐ Recliner, semi
- ☐ Pediatric wheelchair/stroller

Power Operated Vehicles:

- ☐ Group 1
- ☐ Group 2

Power Wheelchairs:

- ☐ Group 1
- ☐ Group 2
- ☐ Group 3
- ☐ Group 4
- ☐ Group 5

Options - Power Wheelchairs:

(Check all that apply)

- ☐ Elevating leg rests
- ☐ Power tilt
- ☐ Power recline
- ☐ Other: _____

Medical necessity justification for the type of base chair requested: _____

Wheelchair Components: **Provide Medical Necessity Justification for each component**

Frame size: _____

Back: _____

Seat: _____

Arm: _____

Front rigging: _____

Drive wheels: _____

Casters: _____

Wheel locks: _____

Interface (power chair): _____

Electronics (ex: controllers, power seating functions): _____

Other: _____

Assembly instructions: _____

Seating Components: Provide Medical Necessity Justification for each component

Seat (including cushion): _____

Back (including cushion): _____

Trunk: _____

Head: _____

Upper extremity: _____

Lower extremity: _____

Other: _____

Cost Comparison:

Medicaid requires that there be coverage for the least expensive, medically necessary device ([7102.2](#)).

Document that EACH of the following devices were considered/trialed and deemed not medically appropriate for the recipient; provide rationale:

Cane/Crutches: _____

Walker: _____

Manual wheelchair (if requesting power device): _____

Lesser manual wheelchair (if requesting a manual device): _____

Power operated vehicle (scooter) (if requesting power wheelchair): _____

Lesser Group Power wheelchair: _____

SIGNATURE SHEET

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Vendor and Therapist Acknowledgement (Please initial each statement):

Vendor	Therapist	
		I have researched, and have not found, any less costly wheelchairs or components that would be appropriate to the individual's medical needs at this time. Any components from the individual's current wheelchair that can be utilized will be placed on the new wheelchair.
		I have explained to the beneficiary that, should any defects develop in the device, the beneficiary must report the defects to the vendor.
		I have explained to the beneficiary that the expectation is that this wheelchair will last for at least 5 years, and should be treated so that it will last for at least 5 years. If there is a change in the beneficiary's size and/or medical condition, consideration can be given to coverage of wheelchair/components sooner than 5 years. I have explained that Medicaid covers the cost of medically necessary repairs so that the device will continue to operate properly and safely for at least 5 years.
		I have instructed the individual/caregivers on safe home and vehicle entry and exit with the wheelchair, or will provide this information at the time of the wheelchair fitting.
		I have explained to the individual/caregivers proper safe operation of the wheelchair, or will provide this information at the time of the wheelchair fitting.
		I have explained to the beneficiary that should the chair no longer fit or no longer be needed, that it is the property of Medicaid and should be returned to Medicaid; and to call the phone number on the sticker that has been placed on the device.
		I have explained to the beneficiary that, should the device be lost or stolen, a police report must be submitted with any request for replacement of the device.
		(Over 21 only): From the measurements provided in this prescription, I have determined that the wheelchair will fit in the beneficiary's mobility-related ADL environment which includes 100 feet beyond the home itself, and is suitable for use therein; that it is required to perform one or more mobility related activities of daily living (feeding, grooming, dressing, and hygiene) and/or to provide medically necessary access to medical care, and fits into the primary transportation device that brings the beneficiary to medically necessary medical care.

Beneficiary/Legal Guardian Acknowledgement (please check or initial each statement):

	I accept the specific wheelchair and/or components being requested on my behalf in this prescription.
	I have had an opportunity to try the wheelchair or a simulation so that I know it will work for me and fit properly in my home.
	I understand how to properly care for and maintain the device so that it can last for at least 5 years OR understand that I will receive this information at the time of the wheelchair fitting.
	I understand that the wheelchair is expected to last at least 5 years, and I will treat it so that it will last for at least 5 years. I understand that if I have a significant change in size or medical condition, that consideration will be given to coverage of wheelchair/components sooner than 5 years. I understand that Medicaid covers the cost of medically necessary repairs so that the device will continue to operate properly and safely for at least 5 years.
	I understand that the device is the property of Medicaid. If it is no longer medically necessary, I understand that I should call the number on the sticker that will be placed on the device.
	I understand how to properly operate the wheelchair, or understand that I will receive this information at the time of the wheelchair fitting.
	I understand that if the device is lost or stolen, a police report must be submitted with any request for replacement of the device.

	(Over 21 only): I require this device to accomplish one or more mobility related activities of daily living (feeding, grooming, dressing, and hygiene) and/or to access medically necessary medical care.
	(Over 21 only): The device fits in my mobility related ADL environment which includes my home, 100 feet beyond the home itself, and in the transportation I use to get to medically necessary medical care.

Comments:

All parties signed below deem this prescription accurate and medically appropriate:

Date	Name (please print)		Signature
		Client or legal guardian	
		Physician	
		*Therapist	
		**Supplier	

*Therapist, include your professional designation (PT, OT)

**Supplier, include your ATP status for wheelchairs requiring ATP certification.

APPENDIX A: DEFINITIONS

December 2015

Manual Wheelchairs (MWC):

Adult manual wheelchairs are those which have a seat width and a seat depth of 15" or greater, and the wheels must be large enough and positioned such that the wheelchair could be propelled by the user. In addition, the specific codes are defined by the following characteristics:

Standard wheelchair

- Weight: Greater than 36 lbs.
- Seat Height: 19" or greater
- Weight capacity: 250 pounds or less

Ultra-lightweight wheelchair

- Weight: Less than 30 lbs
- Adjustable rear axle position
- Lifetime Warranty on side frames and cross braces

Standard hemi (low seat) wheelchair

- Weight: Greater than 36 lbs
- Seat Height: Less than 19"
- Weight capacity: 250 pounds or less

Heavy duty wheelchair

- Weight capacity: Greater than 250 pounds

Extra heavy duty wheelchair

- Weight capacity: Greater than 300 pounds

Lightweight wheelchair

- Weight: 34-36 lbs
- Weight capacity: 250 pounds or less

Adult tilt-in-space wheelchair

- Ability to tilt the frame of the wheelchair greater than or equal to 20 degrees from horizontal while maintaining the same back-to-seat angle.
- Lifetime Warranty on side frames and cross braces

High strength, lightweight wheelchair

- Weight: Less than 34 lbs
- Lifetime Warranty on side frames and cross braces

Additional Notes:

- A Pediatric manual wheelchair is a manual wheelchair with a seat width and/or depth of 14" or less.
- Lightweight, high strength lightweight, ultra-lightweight, heavy duty, extra heavy duty and tilt in space wheelchairs include any seat height.
- Wheelchair "poundage" (lbs.) represents the weight of the usual configuration of the wheelchair with a seat and back but without front riggings.

(Source: Article A25311, Manual Wheelchair Policy Article, NHIC Corp. revision effective 3/1/13.)

Power Wheelchairs (PWC):

Basic Equipment Package - Each power wheelchair code is required to include all these items on initial issue (i.e., no separate billing/payment at the time of initial issue or thereafter unless there is documented need for repair not covered by warranty or a need for modification as prescribed by the medical provider, unless otherwise noted). The statement that an item may be separately billed does not necessarily indicate coverage.

- Lap belt or safety belt. Shoulder harness/straps or chest straps/vest may be billed separately.
- Battery charger, single mode.
- Complete set of tires and casters, any type.
- Leg rests. There is no separate billing/payment if fixed, swing-away, or detachable non-elevating leg rests with or without calf pad are provided. Elevating leg rests may be billed separately.

- Footrests/foot platform. There is no separate billing/payment if fixed, swing-away, or detachable footrests or a foot platform without angle adjustment are provided unless the foot platform is a custom component. There is no separate billing for angle adjustable footplates with Group 1 or 2 PWCs. Angle adjustable footplates may be billed separately with Group 3, 4 and 5 PWCs.
- Armrests. There is no separate billing/payment if fixed, swing-away, or detachable non-adjustable height armrests with arm pad are provided. Adjustable height armrests may be billed separately.
- Any weight specific components (braces, bars, upholstery, brackets, motors, gears, etc.) as required by patient weight capacity.
- Any seat width and depth. Exception: For Group 3 and 4 PWCs with a sling/solid seat/back, the following may be billed separately:
 - For Standard Duty, seat width and/or depth greater than 20 inches;
 - For Heavy Duty, seat width and/or depth greater than 22 inches;
 - For Very Heavy Duty, seat width and/or depth greater than 24 inches;
 - For Extra Heavy Duty, no separate billing.
- Any back width. Exception: For Group 3 and 4 PWCs with a sling/solid seat/back, the following may be billed separately:
 - For Standard Duty, back width greater than 20 inches;
 - For Heavy Duty, back width greater than 22 inches;
 - For Very Heavy Duty, back width greater than 24 inches;
 - For Extra Heavy Duty, no separate billing.
- Controller and Input Device. There is no separate billing/payment if a non-expandable controller and a standard proportional joystick (integrated or remote) is provided. An expandable controller, a nonstandard joystick (i.e., non-proportional or mini, compact or short throw proportional), or other alternative control device may be billed separately.

Code Specific Requirements:

All Group 1 PWCs must meet the following requirements:

- Standard integrated or remote proportional joystick
- Non-expandable controller
- Incapable of upgrade to expandable controller
- Incapable of upgrade to alternative control devices
- May have cross brace construction
- Accommodates non-powered options and seating systems (e.g., recline-only backs, manually elevating leg rests) (except captain's chairs)
- Length - less than or equal to 40 inches
- Width - less than or equal to 24 inches
- Minimum Top End Speed - 3 MPH
- Minimum Range - 5 miles
- Minimum Obstacle Climb - 20 mm [.78 inches]
- Dynamic Stability Incline - 6 degrees [1:10 slope]

All Group 2 PWCs must meet the following requirements:

- Standard integrated or remote proportional joystick
- May have cross brace construction

- Accommodates seating and positioning items (e.g., seat and back cushions, headrests, lateral trunk supports, lateral hip supports, medial thigh supports) (except captain's chairs)
- Length - less than or equal to 48 inches
- Width - less than or equal to 34 inches
- Minimum Top End Speed - 3 MPH
- Minimum Range - 7 miles
- Minimum Obstacle Climb - 40 mm [1.57 inches]
- Dynamic Stability Incline - 6 degrees [1:10 slope]

All Group 3 PWCs must meet the following requirements:

- Standard integrated or remote proportional joystick
- Non-expandable controller
- Capable of upgrade to expandable controller
- Capable of upgrade to alternative control devices
- May not have cross brace construction
- Accommodates seating and positioning items (e.g., seat and back cushions, headrests, lateral trunk supports, lateral hip supports, medial thigh supports) (except captain's chairs) –
- Drive wheel suspension to reduce vibration
- Length - less than or equal to 48 inches
- Width - less than or equal to 34 inches
- Minimum Top End Speed - 4.5 MPH
- Minimum Range - 12 miles
- Minimum Obstacle Climb - 60 mm [2.36 inches]
- Dynamic Stability Incline - 7.5 degrees [1:8 slope]

All Group 4 PWCs must meet the following requirements:

- Standard integrated or remote proportional joystick
- Non-expandable controller
- Capable of upgrade to expandable controller
- Capable of upgrade to alternative control devices
- May not have crossbrace construction
- Accommodates seating and positioning items (e.g., seat and back cushions, headrests, lateral trunk supports, lateral hip supports, medial thigh supports) (except captain's chairs) - Drive wheel suspension to reduce vibration
- Length - less than or equal to 48 inches
- Width - less than or equal to 34 inches
- Minimum Top End Speed - 6 MPH
- Minimum Range - 16 miles
- Minimum Obstacle Climb - 75 mm [2.95 inches]
- Dynamic Stability Incline - 9 degrees [1:6 slope]

All Group 5 PWCs must have the specified components and meet the following requirements:

- Standard integrated or remote proportional joystick
- Non-expandable controller
- Capable of upgrade to expandable controller

- Capable of upgrade to alternative control devices
- Seat width: minimum of 5 one-inch options
- Seat Depth: minimum of 3 one –inch options
- Seat Height: adjustment requirements greater or equal to 3 inches
- Back Height: adjustment requirements minimum of 3 options
- Seat to back angle: range of adjustment – minimum of 12 degrees
- Accommodates non-powered options and seating systems
- Accommodates seating and positioning items (e.g., seat and back cushions, headrests, lateral trunk supports, lateral hip supports, medial thigh supports)
- Adjustability for growth (minimum of 3 inches for width, depth and back height adjustment)
- Special developmental capability (e.g., seat to floor, standing, etc.)
- Drive wheel suspension to reduce vibration
- Length – less than or equal to 48 inches
- Width – less than or equal to 34 inches
- Minimum Top End Speed – 4 mph
- Minimum range – 12 miles
- Minimum Obstacle Climb – 60 mm [2.36 inches]
- Dynamic Stability Incline – 9 degrees [1:6 slope]
- Crash testing – passed

Power Operated Vehicle (POV)

Basic Equipment Package - Each POV is to include all these items on initial issue (e.g., no separate billing/payment at the time of initial issue):

- Battery or batteries required for operation
- Battery charger, single mode
- Weight appropriate upholstery and seating system
- Tiller steering
- Non-expandable controller with proportional response to input
- Complete set of tires
- All accessories needed for safe operation.

Code Specific Requirements:

Group 1 POVs must meet the following requirements:

- Length less than or equal to 48 inches
- Width: less than or equal to 28 inches
- Minimum top End Speed- 3 mph
- Minimum range – 5 miles
- Minimum Obstacle Climb – 20 mm [.78 inches]
- Radius Pivot Turn – less than or equal to 54 inches
- Dynamic Stability Incline – 6 degrees [1:10 slope]

Group 2 POVs must meet the following requirements:

- Length less than or equal to 48 inches
- Width: less than or equal to 28 inches
- Minimum top End Speed - 4 mph
- Minimum range – 10 miles
- Minimum Obstacle Climb – 50 mm [1.97 inches]
- Radius Pivot Turn – less than or equal to 54 inches
- Dynamic Stability Incline – 7.5 degrees [1:8 slope]

(Source: Article for Power Mobility Devices (A36239), NHIC Corp. effective 6/1/11)

Additional Definitions:

Power Options:

- No power option: incapable of accommodating a power tilt, recline, seat elevation, or standing system, although it can accept power elevating leg rests.
- Single power option: the capability to accept and operate a power tilt or power recline or power standing or, for groups 3, 4, and 5, a power seat elevation system, but not a combination power tilt and recline system. It may be able to accommodate power elevating leg rests, seat elevator, and/or standing system in combination with a power tilt or power recline.
- Multiple power options: the capability to accept and operate a combination power tilt and recline. It may also be able to accommodate power elevating leg rests, a power seat elevator, and/or a power standing system.

(Source: Article for Power Mobility Devices (A36239), NHIC Corp. effective October 1 2011)

Power Wheelchair Drive Control Systems:

Interfaces: “The mechanism for controlling the movement of a power wheelchair. Examples include...joystick, sip and puff, chin control, etc.” This device is alternately called a Control Input device.

- Non-proportional Interface: “one which involves a number of switches. Selecting a particular switch determines the direction of the wheelchair, but the speed is preprogrammed. One example of a non-proportional interface is a sip-and-puff mechanism.”
- Proportional Interface: “the direction and amount of movement by the patient controls the direction and speed of the wheelchair. One example...is a standard joystick.”
- Compact proportional joystick: “one which has a maximum excursion of about 15 mm...but requires ...340 grams of force to activate. It can only be used with an expandable controller.”
- Mini-proportional joystick: “one which can be activated by a very low force (...25 grams) and which has a very short displacement (...5 mm...). It can only be used with an expandable controller.”
- Remote Joystick: “the joystick is in one box that is typically mounted on the arm of the wheelchair and the controller electronics are located in a different box that is typically located under the seat of the wheelchair. The joystick is connected to the controller through a low power wire harness. A remote joystick may be used for either hand control, chin control, or attendant control.”
- Standard proportional remote joystick: “requires 340 grams of force to activate and which has an excursion ...of ...25 mm.... It can be used with a non-expandable or an expandable controller.”
- Touchpad: “an interface similar to [a] mouse.”

Controllers: “the microprocessor and other related electronics that receive and interpret input from the [interface] and convert that input into power output which controls speed and direction. A high power wire harness connects the controller to the motor and gears.”

- Non-expandable controller: “may have the ability to control up to 2 power seating actuators (for example, seat elevator and single actuator power elevating leg rests). Can accommodate only an integral joystick or a standard proportional remote joystick...”
- Expandable controller: “capable of accommodating one or more of the following additional functions: other types of proportional input devices (e.g. mini-proportional or compact joysticks, touch pads, chin control, head control, etc.), non-proportional [interfaces] (e.g. sip-and-puff, head array, etc); operate 3 or more powered seating actuators through the drive control;...may also be able to operate one or more of the following: a separate display (i.e. for alternate control devices; other electronic devices (e.g. control of an augmentative speech device or computer through the chair’s drive control)....”
- Integrated proportional joystick and controller: “joystick and controller electronics are in a single box, which is mounted on the arm of the wheelchair.”

Other electronics:

- Harness: “all of the wires, fuse boxes, fuses, circuits, switches, etc. that are required for the operation of an expandable controller. It also includes all the necessary fasteners, connectors, and mounting hardware.”
- Switch: “electronic device which turns power to a particular function either “on” or “off”.

(Source: Article for Power Mobility Devices (A36239), NHIC Corp. effective 6/1/11)

APPENDIX B: CODING INFORMATION

December 2015 Column II codes are included in the allowance for the corresponding Column I code when provided at the same time. Examples of this include, but are not limited to, the following:

Column I	Column II
Power operated vehicle (K0080-K0812)	All options and accessories
Manual Wheelchair base (E1161, E1229, E1231- 38, K0001-9.	E0967, E0981, E0982, E0995, E2205, E2206, E2210, E2220, E2221, E2222, E2224, E2225, E2226, K0015, K0017, K0018, K0019, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0052, K0069, K0070, K0071, K0072
Power wheelchair base groups 1 and 2 (K813-K0843)	E0971, E0978, E0981, E0982, E0995, E1225, E2366, E2367, E2368, E2369, E2370, E2374, E2375, E2376, E2378, E2381, E2382, E2383, E2384, E2385, E2386, E2387, E2388, E2389, E2390, E2391, E2392, E2394, E2395, E2396, K0015, K0018 , K0019, K0037, K0040, K0041, K0042, K0043, K0044, K0045, K0046, K0047, K0051, K0052, K0098
Power wheelchair base groups 3,4, and 5 (K0848-K0891)	E0971, E0978, E0981, E0982, E0995, E1225, E2366, E2367, E2368, E2369, E2370, E2374, E2375, E2376, E2378, E2381, E2382, E2383, E2384, E2385, E2386, E2387, E2388, E2389, E2390, E2391, E2392, E2394, E2395, E2396, K0015, K0017, K0018 , K0019, , K0037, K0037, K0041, K0042, K0043, K0044, K0045, K0046, K0047, K0051, K0052, K0098
E0973	K0017, K0018, K0019
E0950	E1028
E0990	E0995, K0042, K0043, K0044, K0045, K0046, K0047
Power tilt and/or recline systems (E1002-8)	E0973, K0015, K0017, K0018, K0019, K0020, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0051, K0052
E1009-10	E0990, E0995, K0042, K0043, K0044, K0045, K0046, K0047, K0052, K0053, K0195
E2325	E1028
E1020	E1028
K0039	K0038
K0045	K0043, K0044
K0046	K0043
K0047	K0044
K0053	E0990, E0995, K0042, K0043, K0044, K0045, K0046, K0047
K0069	E2220, E2224
K0070	E2211, E2212, E2224
K0071	E2214, E2215, E2225, E2226
K0072	E2219, E2225, E2226
K0077	E2221, E2222, E2225, E2226
K0195	E0995, K0042, K0043, K0044, K0045, K0046, K0047

(Source: Local Coverage Article for Wheelchair Options/Accessories A19829, effective 1/1/13)

Wheelchair Forms and Tools References

December 2015

References

LCD for Manual Wheelchair Bases (L11465), (2013). *NHIC, Corp.* Retrieved June 19, 2013, from:

[http://www.medicarenhic.com/dme/medical_review/mr_lcds/mr_lcd_current/L11465_2013-03-](http://www.medicarenhic.com/dme/medical_review/mr_lcds/mr_lcd_current/L11465_2013-03-01_rev_2013-03_PA_2013-03.pdf)

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New Website : [https://www.cms.gov/medicare-coverage-database/details/lcd-](https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=11465&ContrId=137&ver=43&ContrVer=1&s=55&DocType=All&bc=AgIAAAA)

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